PRINTED: 12/20/2007 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		344004	B. WING			С
NAME OF PR	OVIDER OR SUPPLIER	344004		STREET ADDRESS, CITY, STATE, ZIP CO	-	10/2005
JOHN UM	STEAD HOSP			1003 12TH ST BUTNER, NC 27509		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
A 006	The hospital must hat body legally responsi hospital as an institut have an organized go legally responsible fo	we an effective governing ble for the conduct of the ion. If a hospital does not overning body, the persons or the conduct of the hospital actions specified in this part	AC	100		
	An unannounced vision March 4 and 10, 2 death in the hospital's Based on staff intervihospital documents, chospital policies and governing body failed A) patient's were free care in a safe setting. B) Conditions of Parti	not met as evidenced by: t was made to the hospital 005 to investigate a patient s Admissions unit ward 234. ew, medical record review, observations and review of procedures, the hospital's to ensure that: from neglect and received cipation were met, and patient supervision policies				
A 016	patient safety, as: A) patients were not accordance with hosp. The cumulative effect resulted in the hospita patients received care A) Cross refer: Tag CFR 482.12(c). The ensure proper patient hospital's policies and	of these systemic problems al's inability to ensure in a safe environment. A0016 Governing Body, governing body failed to a care as required by the diprocedures.	A	016		
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATURI	<u> </u>	TITLE		(X6) DATE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 016	Continued From page	e 1	A 0	16			
		ospital policy, the governing at specific patient care t.					
	Based on staff intervi observations, and rev procedures, the hosp to ensure hospital po implemented and spe	not met as evidenced by: ew, medical record review, view of hospital policies and ital's governing body failed licies and procedures were ecific patient care needs ital's Admissions unit ward					
	of Care, CFR 482.23	A0204 Staffing and Delivery (b)(3). Nursing staff failed to ecordance with hospital res.					
		A 057 Privacy and Safety- espital staff failed to ensure e in a safe setting.					
A 038			A 0	38			
	A hospital must prote each patient.	ct and promote the rights of					
	Based on medical rec procedures review, h	not met as evidenced by: cord review, policies and ospital document review and nospital failed to protect and					

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A 038	neglect, and be proviprevent a patient from Specifically, staff did the Admissions unit whospital policy and proving patient safety. Cross refer: Tag A (-482.13(c)(2) The hospital failed to received care in a saron the Admissions unfollowed hospital policy patients. Cross refer: Tag A (-482.13(c)(3) The hospital failed to (patients) Cross refer: Tag A (-482.13(c)(3) The hospital failed to (patient #1) was free including neglect by finecessary to prevent 482.13(c)(2) RECEIV SETTING The patient has the risetting. This STANDARD is Based on medical recreview of policy and phospital documents, a hospital failed to provite safety for 12 of 12 feet and provided and pro	ded with staff supervision to a self-injurious behavior. not provide supervision on ward 234 in accordance with ocedure. was cited due to the lack of D57 Privacy and Safety-ensure 12 of 12 patients fe setting (patients #1-#12) bit by failing to ensure staff by regarding supervision of D58 Privacy and Safety-ensure one of one patient from all forms of abuse failing to provide services physical harm to patient #1. TE CARE IN A SAFE The provide services with the patient from all forms of abuse failing to provide services physical harm to patient #1. TE CARE IN A SAFE with the patient with the p		038			
	Findings include:						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MUL A. BUILD	TIPLE CONSTRUCTION	, , ,	(X3) DATE SURVEY COMPLETED	
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A 057	revealed Patient #1, admitted to the Adult on 2-21-05 with the coundifferentiated. Repeath" in the medica died on 3-3-05 and the was "suicide". On 3-10-05 the "Adult Assignments" documentation in the slots was illegible for documentation for 5: marked through. An interview was contined to the Adult Assignments and the adult Acheck Sheet", dated Sheet" listed patient Ward 234), room nur Assault, Suicide) and abbreviated code) of 30 minute increments 4:00pm, etc.) Further Check Sheet" revealer oom (abbreviated Redocumentation in the slots was illegible for documentation for 5: marked through).	eview conducted on 3-4-05 a 22-year old male, was Admissions Unit (Ward 234) liagnosis of Schizophrenia - view of the "Certificate of I record revealed Patient #1 ne immediate cause of death It Admissions Unit Ward nent, dated 3-3-05, was ment confirmed that Staff #1 nician who worked second 3-3-05) was responsible for the checks from 5:00pm until ient #1's medical record dmissions Unit Patient 3-3-05. The "Patient Check names (each patient for nber, restrictions (ie Escape, I the location (using an each patient documented in s (ie 3:00pm, 3:30pm, r review of the "Patient ed Patient #1 was in his m) at 5:00pm. The 5:30pm and 6:00pm time Patient #1 (The 30pm and 6:00pm was	A 08				
	responsible for the "F 5:00pm until 7:00pm	ian (Staff #1) who was Patient Check Sheet" from on 3-3-05. Staff #1 reported on the "Patient Check Sheet"					

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A 057	show up for his tray" 6:00pm box on the "F" #1 stated "I didn't know #1 reported he called 5:30pm to get his me patient (Patient #1) at finished giving out trapatient out of his room then he started acting resident settled and the time around 5:45/5. Staff #1 went back to and informed Staff #2 during second shift out find Patient #1. Staff and found Patient #1. The hospital policy er Patients" was reviews stated "It is the respersonnel assigned of for patient movement "Rounds should invite patient". There was Check Sheet" or in intimized contact was made to the time and session of the personnel file for 3-10-05. Review of Scompleted the AAU (Assessment Checklish Assessment Checklish been trained to maint and document the dedocumentation policy	ch meant "the patient did not (dinner tray). For the Patient Check Sheet", Staff ow what to put there." Staff out Patient #1's name at all tray and "didn't see the it 5:30pm". Staff #1 stated "I yes. I went to get another in because he's diabetic and it out. I got that other intensive men went to get (Patient #1's 1:48pm". Interview revealed the desk (nurses' station) is (charge nurse on ward 234 in 3-3-05) that he could not if #1 and #2 went searching hanging in the shower. Intitled "Accounting for it is do no 3-4-05. The policy consibility of nursing irrect patient care to account." The policy further stated olive visual contact with the is no evidence on the "Patient erview with Staff #1 that ade with Patient #1 at Staff #1 was reviewed on Staff #1's file revealed he Adult Admissions Unit) it on 1-5-05. The AAU it indicated that Staff #1 had ain the safety of the milieu livery of care per nursing	A 057				

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A 057	3:55pm and reques checks at 4:00pm which care Technician (Significant Surveyor and provided at 3-10-05. At 3 sheet" already cont 4:00pm and 4:30pm Interview with Staff was an accident" (in 4:00pm and 4:30pm pre-documented). State of the Foundations Group ward 234) and the place off the ward. Patients, dated 3-10 participate in the Foundations Group ward in the Fitness the "Patient Checks which was a countabil with the same was occurred to Patient The personnel file with Staff #4. Review of completed the AAU 1-7-05. The AAU A indicated that Staff	arrived to Ward 234 at ted to make 30 minute patient with the responsible Health taff #4). Staff #4 approached led the "Patient Check Sheet", 5:55pm the "Patient Check ained documentation for the attime slots. #4 on 3-10-05 revealed "this town an accident that the attimes slots had been staff #4 further reported that ing held from 3:30-4:30pm: oup that is held on the ward Fitness Group that takes Staff #4 provided a list of 11 lo-05, that were scheduled town and attimes slots for all patients on owere on the ward in the and those who were off the Group). By pre-documenting Sheet", the hospital failed to the hospital policy "Accounting the to follow this policy ety of each patient on Ward of where actual harm had	A	057				

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A 057	policy. Hospital staff failed to patients on ward 234 supervise and make on 3-3-05 at 5:30pm hospital's policy and "Accounting for Patient Administrative staff in confirmed Staff #1 a not follow the hospit entitled "Accounting 482.13(c)(3) FREE FEARASSMENT	o provide supervision for 4 on 3-10-05 and failed to visual contact with Patient #1 in accordance with the procedure entitled ents". Interview on 3-10-05 and Staff #4 on ward 234 did al's policy and procedure for Patients". FROM ABUSE &		057			
	Based on medical repolicy and procedure document review, the one of one patient (preglect by failing to prevent physical harms. Findings include: An unannounced deconducted on ward 2 the hospital on March Medical record revier revealed Patient #1, admitted to the Adultical record revier.	not met as evidenced by: ecord review, staff interviews, es review, and hospital ne hospital failed to ensure patient #1) was free from provide services necessary to m to patient #1. ath investigation was 234 of the Admissions Unit of h 4 and March 10, 2005. w conducted on 3-4-05 a 22-year old male, was t Admissions Unit (Ward 234) diagnosis of Schizophrenia -					

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A 058	Undifferentiated. Rev Death" in the medical died on 3-3-05 and the was "suicide". Review of Patient #1' Psychiatric Assessme physician and dated a endorses auditory ha years, feels they have unsure how long. He understand what the command auditory ha knife the day prior to himself". The Psycrevealed Patient #1 ". homicidal ideations" Further review of Pati revealed the physicia (the day of admission Patient #1 was placed According to a physic 2-21-05 at 2:00pm, F (Assault Precautions) seems angry". Further orders revealed an or 6:00pm, which stated Further review of the Patient #1 was placed on 2-28-05 at 4:45pm physician's progress 5:45pm, Patient #1 w Precautions) for "show escape". There was record that revealed is suicide precautions.	view of the "Certificate of record revealed Patient #1 e immediate cause of death and completed by the 2-21-05, which stated "He ducinations over the last two e been worse recently, but is states he does not voices say, denies allucinations, but did get a admission with plans to kill hiatric Assessment alsocurrently denies suicidal or "." ent #1's medical record in's orders, dated 2-21-05 at 10:30am, in which don Assault Precautions. Cian's progress note, dated Patient #1 was placed on AP is because "staff feel pt. er review of the physician's orders revealed don "Escape Precautions" in According to the note, dated 2-28-05 at as placed on EP (Escape	A	0058					

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A 058	physician on 3-10-05 that Patient #1's mair was auditory hallucindenied command AH Patient #1 "never expto me" and that he "simproving". The physician before the suicide (3-hallucinations were invoiced by Patient #1's LPN (Staff #3) progres 5:15pm, which stated (by mouth) and Haldod 4:20pm. Client in because of the Medica (MAR) confirmed Pathaldol at 4:20pm. A telephone interview #3 on 3-14-04 at 3:33 usually works on War 234 on the second shreported Patient #1 remedication because agitated". Staff #3 counter that Patient his room (around 4:3) unlocked Patient #1's are usually locked be groups). Staff #3 rep to go to his supervisor Patient #1 prior to lear "5:10-5:15pm, I think" I walked in the room bed asleep on his left.	The physician reported a complaint upon admission ations (AH), but Patient #1 The physician stated that bressed SI (suicidal ideation) eemed to be steadily sician reported that the day 2-04) Patient #1's auditory inproving and that no SI was at that time. Is medical record revealed a ress note, dated 3-3-05 at 1 "Client given Ativan 1mg pool 5mg for agitation at diasleep at this time". In this interior is a state of the state o	A	058			

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A 058	5:10-5:15pm prior to land Additional review of Frevealed a progress of 5:50pm, in which a H#1) documented "A (patient) room and did nurses' desk, report of RN (Registered Nurse found him in bathroor leather belt tied arour crouch down in show call code. Pull pt out and AAD (automatic of the progress notes a Registered Nurse (6:00pm, which stated that pt. had not eaten HCT for pt's was unsithed to pt's room and his room. Pt. unresponsel buckled tightly arreview of the progress documentation by a p6:25pm through 6:32pd documented "Resport (physician's name) arresponding, CPR beil unresponsive, pupils unsuccessful, pt pronunces of the "Adul Assignments" documereviewed. The documereviewed. The documereviewed. The documereviewed. The documereviewed. The documented "Responsible for the form 5:00pm until 7:00.	Patient #1's medical record note, dated 3-3-05 at ealth Care Technician (Staff t 5:48 I approached pt d not see him. Approached lid not see him. Writer an e) went back to room and m shower with a brown and neck and tie to rail. Pt. er. Unloosen belt while Rn of shower and got red bag defibrillator)". Further review revealed documentation by Staff #2), dated 3-3-05 at "HCT (Staff #1) notified me supper. Initial search by uccessfulWriter went with found pt. in shower stall of onsive and grey at lips with ound his neck" Further is notes revealed only sician, dated 3-3-05 at om. The physician ded to Code Blue, found and (physician's name) on site notes performed, pt dilated, fixed. CPR ounced dead at 6:23pm It Admissions Unit Ward ent, dated 3-3-05, was ment confirmed that Staff #1 ne 30 minute patient checks	A 05	58			

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A 058	Check Sheet", dated Sheet" listed patient Ward 234), room nun Assault, Suicide) and abbreviated code) of 30 minute increments 4:00pm, etc.) Furthe Check Sheet" revealer room (abbreviated Rrdocumentation in the slots was illegible for documentation for 5:5 marked through). An interview was con Health Care Technici responsible for the "F 5:00pm until 7:00pm that the 5:30pm box ostated "refused", which show up for his tray" 6:00pm box on the "F #1 stated "I didn't know #1 reported he called 5:30pm to get his me patient (Patient #1) at finished giving out trapatient out of his room then he started acting resident settled and the name) around 5:45/5 Staff #1 went back to and informed Staff #2 Patient #1. Staff #1 found Patient #1 hard Staff #1 also stated "I with him (Patient #1)	3-3-05. The "Patient Check names (each patient for ober, restrictions (ie Escape, the location (using an each patient documented in a (ie 3:00pm, 3:30pm, review of the "Patient ed Patient #1 was in his en) at 5:00pm. The 5:30pm and 6:00pm time Patient #1 (The 30pm and 6:00pm was ducted on 3-4-05 with the ean (Staff #1) who was eatient Check Sheet" from son 3-3-05. Staff #1 reported for the "Patient Check Sheet" eth meant "the patient did not (dinner tray). For the eatient Check Sheet", Staff ew what to put there." Staff out Patient #1's name at eal tray and "didn't see the a 5:30pm". Staff #1 stated "I ys. I went to get another enen went to get (Patient #1's eather	A	058			

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A 058	worked with him (Pat stayed to himself and with him if I gave him An interview was cor #2, who was charge second shift on 3-3-0 have a lot of contact reported Patient #1 v (more verbal and mo in the conversation with the	im like I always do. I had ient #1) all weekend. He is I got a positive response in encouragement". Iducted on 3-4-05 with Staff nurse on Ward 234 during is 5. Staff #2 stated "I didn't with the patient", but was a little more "present" re eye contact per Staff #2) with Staff #1. Its written by Staff #1 and #2 of Patient #1 were reviewed. It and dated their respective is stating that the information in and #2 had written the inspital document entitled went gation Statement" as part of a investigation.	A 05	8			

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A 058	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 12 Assessment Checklist on 1-5-05. The AAU Assessment Checklist indicated that Staff #1 had been trained to maintain the safety of the milieu and document the delivery of care per nursing documentation policy. Staff neglected to provide care and services to protect patient #1 from self-injurious behavior. The hospital staff failed to provide supervision and make visual contact with patient #1 on 3-3-05 at 5:30pm in accordance with the hospital's policy entitled "Accounting for Patients". Administrative staff interview on 3-10-05 confirmed Staff #1 on ward 234 did not follow the hospital's policy and procedure entitled "Accounting for Patients" on 3-3-05 at 5:30pm.			199				

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A 199	Continued From page 13		A	199			
A 204	Care, CFR 482.23(b) monitor patients in ac policies and procedu	204 Staffing and Delivery of (3). Nursing staff failed to ecordance with hospital res. PERVISION OF NURSING	A	204			
	A registered nurse m the nursing care for e	ust supervise and evaluate ach patient.					
	Based on staff intervi and policies and proc failed to ensure that a supervised and evalu specifically, nursing monitor patients in ac	_					
	Immediate Jeopardy patient safety.	was cited due to the lack of					
	Findings include:						
	revealed Patient #1, a admitted to the Adult on 2-21-05 with the d Undifferentiated. Rev Death" in the medica	eview conducted on 3-4-05 a 22-year old male, was Admissions Unit (Ward 234) iagnosis of Schizophrenia - view of the "Certificate of I record revealed Patient #1 ie immediate cause of death					
	Assignments" docum	t Admissions Unit Ward ent, dated 3-3-05, was ment confirmed that Staff #1					

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		B. WING _		03	C 03/10/2005		
NAME OF PROVIDER OR SUPPLIER JOHN UMSTEAD HOSP				TREET ADDRESS, CITY, STATE, ZIP CO 1003 12TH ST BUTNER, NC 27509	•	10/2005	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ΓΙΟΝ SHOULD BE ΤΗΕ APPROPRIATE	(X5) COMPLETION DATE	
A 204	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		A 20-	4			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
	344004		B. WING			C 03/10/2005		
NAME OF PROVIDER OR SUPPLIER JOHN UMSTEAD HOSP			•	100	T ADDRESS, CITY, STATE, ZIP CODE 3 12TH ST TNER, NC 27509			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	SHOULD BE COMPLET		
A 204	during second shift of find Patient #1. Staff and found Patient #1. The hospital policy er Patients" was review stated "It is the respersonnel assigned of for patient movement "Rounds should invite patient". There was Check Sheet"or in intivisual contact was missisopm on 3-3-05. The personnel file for 3-10-05. Review of Scompleted the AAU (Assessment Checklist Assessment Checklist Assessment the dedocumentation policy 2) Observations were 234. The surveyor and document the dedocumentation policy 2) Observations were 234. The surveyor and requested checks at 4:00pm with Care Technician (State Surveyor and provided dated 3-10-05. At 3:5 Sheet" already contails 4:00pm and 4:30pm for the stafe and surveyor and 4:30pm for the stafe and 5:30pm for the stafe and 5:3	2 (charge nurse on ward 234 in 3-3-05) that he could not if #1 and #2 went searching hanging in the shower. Intitled "Accounting for ed on 3-4-05. The policy consibility of nursing direct patient care to account it." The policy further stated volve visual contact with the is no evidence on the "Patient erview with Staff #1 that add with Patient #1 at Staff #1 was reviewed on Staff #1's file revealed he Adult Admissions Unit) is on 1-5-05. The AAU is indicated that Staff #1 had it indicated had it indicated that Staff #1 had it indicated	A	204				
	was an accident" (it 4:00pm and 4:30pm	was an accident that the						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
			B. WING		С		
		344004	B. WING		03	03/10/2005	
NAME OF PROVIDER OR SUPPLIER JOHN UMSTEAD HOSP			100	ET ADDRESS, CITY, STATE, ZIP COD 3 12TH ST TNER, NC 27509	ÞΕ		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
A 204	two groups were being the Foundations Group (ward 234) and the Fiplace off the ward. Spatients, dated 3-10-participate in the Foundations Group at the ward (those who Foundations Group at ward in the Fitness Group at the "Patient Check Sprovide accountability #234 as outlined in the Foundations". Failure jeopardized the safet #234, the same ward occurred to Patient # The personnel file was Staff #4. Review of completed the AAU And 1-7-05. The AAU And indicated that Staff #4 maintain the safety of the delivery of care prolicy. Hospital staff failed to patients on ward 234 supervise and make on 3-3-05 at 5:30pm hospital's policy and "Accounting for Patien Administrative staff in confirmed Staff #1 ar	ing held from 3:30-4:30pm: up that is held on the ward itness Group that takes Staff #4 provided a list of 11 05, that were scheduled to indations Group on Ward catient list revealed that the ire pre-documented for the itime slots for all patients on it were on the ward in the ind those who were off the it for each patient on Ward ine hospital policy "Accounting it for each patient on Ward ine hospital policy "Accounting it follow this policy it of each patient on Ward where actual harm had if on 3-3-05. The reviewed on 3-10-05 for it for staff #4's file revealed he is it is reviewed to it is the milieu and document it is reviewed to it is the milieu and document it is the milieu and document it is in accordance with the in accordance with the in accordance with the in accordance entitled ints".	A 204				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLE	(X3) DATE SURVEY COMPLETED	
		A. BUILDING		С			
		344004	B. WING		03/10/2005		
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A 204	Continued From page entitled "Accounting f		A 204				